



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID WEST DO
3100 TIMMONS LANE, STE 250
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

METROPOLITAN TRANSIT AUTHORITY HARRIS CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4161-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary, as stated on the Table of Disputed Services: "Carrier refuses to pay full amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: \$810.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see attached EOBs. This was an untimely requested FCE. See Rule 130.6(e)...Starr Comprehensive Solutions is responding to the Medical Dispute Resolution...The documentation submitted does not meet the level of service required for an FCE. The documentation lacked elements required per rule 134.204(g). The elements the FCE lacked were stated on the EOBs."

Response Submitted by: Flahive, Ogden & Latson; PO Drawer 201329; Austin TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2011	97750-FC	\$810.40	\$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 1, 2011

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 138 – Appeal procedures not followed or time limits not met.
- Comments: 138 – Untimely DD referred FCE. Per Rule 130.6(e) Additional testing must be completed within ten working days of the designated doctor's physical examination of the employee. DD physical examination occurred on 4/26/11..
- Comments: 150 - Documentation submitted does not support the level of service required for a FCE. Per DWC rule 134.204(g): FCEs shall also include the following elements: (1) A physical examination and neurological evaluation, which include the following: (A) appearance (observational and palpation); (B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities; (D) vascular integrity; (E) neurological tests to detect sensory deficit; (F) myotomal strength to detect gross motor deficit; and (G) reflexes to detect neurological reflex symmetry.
- Documentation submitted does not support billing for 16 units of code 97750, No start and stop times provided. Documentation must include the time for the evaluation and testing only. The interpretation/report time is an integral part of the FCE reimbursement and should not be included in the billing time.

Explanation of benefits dated June 20, 2011

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 193 - Original payment decision is being maintained. The claim was processed properly the first time.
- Comments: 150 - Documentation submitted does not support the level of service required for a FCE. Per DWC rule 134.204(g): FCEs shall also include the following elements: (1) A physical examination and neurological evaluation, which include the following: (A) appearance (observational and palpation); (B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities; (D) vascular integrity; (E) neurological tests to detect sensory deficit; (F) myotomal strength to detect gross motor deficit; and (G) reflexes to detect neurological reflex symmetry.
- Documentation submitted does not support billing for 16 units of code 97750, No start and stop times provided. Documentation must include the time for the evaluation and testing only. The interpretation/report time is an integral part of the FCE reimbursement and should not be included in the billing time.

Issues

1. Was denial reason code "138" upheld upon reconsideration in this fee dispute?
2. Were all the documentation requirements of an FCE met per 28 Texas Administrative Code §134.204(g)?
3. Does the submitted documentation support the level of service for the 16 units billed?
4. Is the requestor entitled to reimbursement?

Findings

1. Denial reason code "138 - Untimely DD referred FCE..." was not upheld upon reconsideration; therefore this denial reason code will not be considered in this review.
2. The respondent denied the FCE based upon "150 – Documentation submitted does not support the level of service required for an FCE. Per 28 Texas Administrative Code §134.204(g): FCEs shall also include the following elements:
(1) A physical examination and neurological evaluation, which include the following:
(A) Appearance (observational and palpation);
(B) Flexibility of the extremity joint or spinal region (usually observational);
(C) Posture and deformities;
(D) Vascular integrity;
(E) Neurological tests to detect sensory deficit;
(F) Myotomal strength to detect gross motor deficit; and
(G) Reflexes to detect neurological reflex symmetry".

The documentation submitted by the requestor in this dispute was reviewed. The documentation does not sufficiently support a physical examination and a neurological evaluation.

3. A further review of the documentation submitted by the requestor in this dispute reveals the following: The Functional Capacity Evaluation Report cover page states, "Total Test Time: 4 hours. Includes: Patient Questionnaire; Interview; Test Modalities, Interpretation/Report". No specific start and stop time was documented; however, each test that was documented included start times as follows: cardiovascular intake

started 1:18pm; range of motion test – lumbar started 1:27pm; strength test (hand grip) started 1:32pm; strength test (UTM) started 1:54pm; work simulation test (dynamic lift) started 2:11pm; work simulation test (dynamic carry) started 2:42pm; work simulation test (positional) started 2:49pm; and cardiovascular test (treadmill) started 3:30pm and terminated after 1.23 minutes. Total documented time sufficiently supported 2 hours or 8 units. No documentation was found to support “total test time: 4 hours” or the 16 units as billed.

4. Therefore, all documentation requirements of an FCE were not met according to 28 Texas Administrative Code §134.204(g). No reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

Authorized Signature

_____	_____	January _____, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.